Minnesota Public Employees Insurance Program

EMPLOYEE ENROLLMENT

EMPLOYER USE ONLY

❑ **New Employee** ❑ **Annual Enrollment** ❑ **Late Entrant (attach letter of explanation)**

Date of Hire ❑ **COBRA** ❑ **Early Retiree**

_____ ❑ **Return from Leave** ❑ **Other (attach letter of explanation)**

Effective Date

EMPLOYEE INFORMATION

Social Security Number	Employer		
Name		Work Phone	Home Phone
Address		❑ Male ❑ Female	Date of Birth
City	State	Zip	❑ Single ❑ Married

Will you or your spouse have other health coverage or Medicare while covered under PEIP? ❑ Yes ❑ No If yes, complete the following:

Spouse Name	Name of Health Plan	Spouse Date of Birth

WAIVER OF COVERAGE

Complete this section only if you are NOT enrolling in the Minnesota Public Employees Insurance Program.

Check appropriate box:

❑ I am waiving coverage in the Minnesota *Public Employees Insurance Program* at this time because I have coverage under another plan.

❑ I am waiving coverage in the Minnesota *Public Employees Insurance Program* and do not have coverage under another plan. I understand if, at a later date, I request any coverage under the Minnesota *Public Employees Insurance Program*, I may be subject to a pre-existing condition exclusion or I may have to provide proof of prior continuous coverage.

Employee Signature	Date

COVERAGE OPTIONS

Health Plan choice: (one per family)

❑ HealthPartners
❑ Blue Cross Blue Shield

Benefit Level: (choose one):

❑ Advantage High Plan
❑ Advantage HSA Plan

Who do you wish to cover? Check all that apply.

❑ Employee Only
❑ Employee + Spouse
❑ Employee + Child(ren)
❑ Family

LIFE

❑ Basic Life/AD&D Insurance (check with your employer for amount) ❑ Dependent/Spouse Life Insurance

❑ Employee Supplemental Life/AD&D Insurance - Amount: _____ (increments of $5,000 upon approval)

Life Insurance Beneficiary Designation:

Primary: Relationship:

Secondary: Relationship:

DENTAL

❑ Employee Dental Coverage ❑ Employee and Dependent Dental Coverage

LIST EMPLOYEE & ALL DEPENDENTS TO BE COVERED

Last Name, First Name, Middle Initial (use additional paper if necessary)	Date of Birth (Month/Date/Year)	M	F	Social Security Number	Primary Care Clinic Name & Clinic #
Employee					
Spouse					
Child					
Child					
Child					

SIGNATURE

I am applying for coverage in the Minnesota *Public Employees Insurance Program* subject to approval of my eligibility. I authorize my employer to disclose the foregoing information to the Minnesota *Public Employees Insurance Program*, the insurance carrier indicated, and any other agent, for use in determining my eligibility to participate in the Program, in processing my application, and for any other reasons as set forth on the reverse of this application. This authorization is valid until revoked by operation of law. If paid through the payroll system, I authorize payroll deduction for my share of the premiums.

_____ _____

Employee Signature Date

There are laws to protect your rights to:
INFORMATION AND PRIVACY

INFORMATION AND PRIVACY

Several state and federal laws aid in protecting your right to privacy and make it easier for you to review information in your insurance file. Under one of these laws, the Minnesota Government Data Practices Act (Minnesota Statutes 13.01-13.43), you have the right to know:

A. Why the information is needed:

The information we request about you, your employment, and family members is needed for one or more of the following reasons:

- Determine whether you are eligible for the Minnesota *Public Employees Insurance Program* (PEIP).
- To establish the amount of insurance coverages you and/or your family members are eligible for.

B. Your rights regarding supplying information:

Minnesota Statute 13.04. You may refuse to provide the information we request; however, without certain minimal information, we may be unable to process your application for insurance coverage under the group plan.

Federal Privacy Act of 1974: Public Law 93-579. Disclosure of your social security number is voluntary. It is being requested to identify your records in the Minnesota *Public Employees Insurance Program* system maintained by the administrative organization responsible for enrollment, and claims processing procedures for the Program. It is also used for the records maintained by insurance companies. While you are not legally required to furnish this information, processing of your application for group benefits may be delayed without it.

C. Who the information is used by and how it is used:

The information we collect will be used by employees of the Minnesota *Public Employees Insurance Program*'s administrative organization operating the group insurance program, federal and state tax authorities, and will be shared with the insurance carrier(s) and administrator involved in providing your benefits.

Depending on the coverage you request (and are eligible for), information may be used to:

- Provide enrollment and/or change information to your insurance carrier(s) and the Minnesota *Public Employees Insurance Program* administrative organization so they can provide benefits and pay claims.
- When required, provide underwriting information to insurance carrier(s) necessary to acquire insurance coverage.
- Prepare statistical reports and evaluative studies.

When you are no longer an active participant under the group insurance plan, your file will be kept until state document retention requirements are met.

D. What information you have access to:

You may request in writing to be shown insurance information about yourself that is maintained by your employer.

E. How can you obtain information on your benefit files:

Questions regarding your eligibility, level of coverage, and premium rates should be directed to the designated insurance representative for your employer. Questions regarding medical, dental or life insurance claims should be directed to the specific plan chosen.